

**COUNTY DEPARTMENT OF SOCIAL SERVICES  
ADOPTION ASSISTANCE**

TO: Providers of Psychological, Therapeutic, or Remedial Services  
RE: Instructions for Payment

\_\_\_\_\_ is certified for Adoption Assistance.  
(Child's Name)

Adoption Assistance will provide payment, not to exceed a total of \$1200.00 per year, for services related to the treatment of the following condition(s): (Describe handicapping condition(s).) \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Please sign and attach one identifying label, provided by the parent(s), to **two copies** of your bill.

Submit to: \_\_\_\_\_ County Department of Social Services

Address: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

In compliance with N.C. General Statute 108A-50, the claim must represent only the amount due after all health insurance claims have been processed.

**NOTE:**

The DSS-5113 is to be ordered from the Division of Social Services. The DSS-5113 is to be provided to the adoptive parent(s) to give to each medical provider of psychological, therapeutic or remedial services.